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ABSTRACT

A report on a 1981 seminar on continuing education for primary health care, sponsored by the World Health Organization's Regional Office for Europe is presented. The main purpose of the seminar was to determine the characteristics of continuing education as a support measure for primary health care provision, based on an analysis of the "Regional Strategy for Attaining Health for All by the Year 2000," which is appended. Another purpose was to demonstrate and test a method of formulating health care and health service problems, identifying and analyzing the functions and tasks required to deal with these problems, and deriving the competencies, skills, and attitudes that primary health care workers will need in order to perform the tasks. In introducing the first working session of the seminar, A. Wojtczak described the background to the "European Regional Strategy," which is a statement of policy and method regarding principles and guidelines for organizing a continuing education service in support of primary health care. Participants had an opportunity to obtain clarification of aspects of the strategy and to relate it to the conditions in their countries. Twenty-three characteristics that organizers of continuing education in support of primary health care can use to appraise existing educational programs or in planning new systems or services are outlined, based on the group sessions. Appended materials address strategies to promote lifestyles conducive to health, problems related to lifestyles, the physical and social environment, and failings of health services. A list of participants is included. (SW)

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CONTINUING EDUCATION FOR PRIMARY HEALTH CARE

Report on a Seminar

San Remo
19-21 October 1981

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WORLD HEALTH ORGANIZATION
Regional Office for Europe
COPENHAGEN

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CONTENTS

		Page
1.	Introduction	1
2.	Why continuing education for primary health care?	2
3.	Competencies and skills for primary health care	4
	3.1 The method used by the Seminar to identify PHC competencies and skills.	4
	3.2 The new competencies and skills for primary health care	5
4.	Continuing education in support of primary health care: conditions, organization, methods	6
5.	Conclusion	12
Annex 1(a)	Regional strategy for attaining health for all	13
Annex 1(b)	Regional programme in health education and lifestyles	18
Annex 2	Identification of functions and tasks in primary health care summary of work of groups	20
Annex 3	List of participants	23

1. Introduction

The Regional Committee for Europe of the World Health Organization at its 1980 meeting adopted the Regional Strategy for Attaining Health for All by the Year 2000[a] as the European component of the corresponding Global Strategy[b] adopted in 1981 by the World Health Assembly. The Assembly, in 1979, had declared primary health care to be the key to attaining an acceptable level of health for all.[c] Earlier, in 1978, the Alma-Ata Conference on Primary Health Care[d] had described in broad outline the nature and scope of primary health care; the strategy adopted by the Regional Committee for Europe is in essence the application of the Alma-Ata concept of primary health care to the European Region. It is for countries to adapt it to their special needs and conditions, and to add to it other elements as they see fit to do so.

The regional strategy has far-reaching implications for the organization and practice of health care in the European Region. These implications at present are far from being worked out in detail or in the many different forms in which the countries of the Region will eventually put them into practice. It has correspondingly important implications for the education and training of the health care workers, professional and nonprofessional, who will be the practitioners of primary health care, because the new orientation of practice will demand profound changes in attitude, competencies and skills, and in modes of health care practice. While education and training alone cannot be expected to bring about the necessary reorientation of health services and changes in health care practice, these cannot come about without a considerable effort in education and training. There are two crucial considerations. One is that most of the health care professionals - medical, nursing, sanitarian, social work, and others - upon whom the reorientation of health care practice will depend are already in practice or will be entering practice in the next few years; their training has not taken any account of the changes that must be made in primary care if their countries put into effect the strategy they have adopted for attaining health for all. The other consideration is that there are very few "experts" in the practice of the new primary health care; there is no comprehensive operational model, and there are few people with experience, on which to base the retraining of those health care workers already in practice or the education and training of undergraduate students of the health professions. This means that the countries of the European Region, now committed to the Regional Strategy for Attaining Health for All by the Year 2000, at the same time as they set about reorienting their health care services, are faced with the problem of finding ways and providing opportunities for the health care workers concerned to learn the new competencies and skills that the primary health care approach calls for. This problem, therefore, of continuing education for primary health care, the WHO Regional Office for Europe sees as one on which countries have to take early action and one which must be given a high place in its programme, particulary for the six-year period of the Seventh General Programme of Work of WHO, namely 1984-1989.

For this reason the Regional Office, with the collaboration of the Government of Italy, organized a Seminar on the Continuing Education of Health Workers in Primary Health Care, at San Remo at the Centre for Medical Education from 19 to 21 October 1981. Its main purpose was to determine from an analysis of the Regional Strategy what should be the characteristics of a continuing education
service that health authorities or professional associations could use as a support measure for primary health care. Another purpose was to demonstrate and test a method or process of formulating health-care and health-service problems, identifying and analysing the functions and tasks required to deal with these problems, deriving the competencies, skills and attitudes that primary health care workers will need in order to perform the identified functions and tasks, and from there identifying the main characteristics of a continuing education system - its organization, its relations to the primary health care system, and its methodology - as a support measure to primary health care.

The Seminar participants numbered 24, from 15 countries of the European Region, together with four WHO staff members (see Annex 3, List of Participants). At the formal opening session they were welcomed by Professor R. Vannugli, Director of International Relations at the Ministry of

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[a] Document EUR/RC30/8.

[b] Global Strategy for Health for All by the Year 2000, Geneva, World Health Organization, 1981.

[c] World Health Organization: Handbook of Resolutions and Decisions. Geneva, World Health Organization, 1978.

[d] Alma-Ata 1978: primary health care. Geneva, World Health Organization, 1978 (Health for All Series, No.1).

Health of Italy; the Deputy Mayor of San Remo, on behalf of the Province of Imperia;[a] Dr G. Lotti, Director of the Centre for Medical Education at the Villa Nobel, San Remo; and Dr A. Wojtczak, Director of the Service of Research, Planning and Human Resources at the WHO Regional Office for Europe, on behalf of the Regional Director, Dr Leo A. Kaprio.

Dr G. Lotti was elected Chairman of the group, and Miss A. Lavan and Ms H. Sammalkorpi as Vice-Chairmen; Dr J. Gallagher, Secretary of the meeting, was elected Rapporteur.

2. Why continuing education for primary health care?

In introducing the first working session of the Seminar, Dr A. Wojtczak described the background to the European Regional Strategy for Attaining Health for All by the Year 2000, a strategy which should be seen as a collaborative effort between WHO and its Member States, drawn up on the basis of a considerable amount of consultation between the WHO Regional Office and the countries of the Region. This background is reflected in the report of the Alma-Ata Conference on Primary Health Care[b] and, in relation to Europe, in the publication Primary Health Care in Europe,[c] as well as in the European regional strategy document, of which an abridged version was prepared for the Seminar (Annex 1(a), (b)). It is essential to take this background into account in any consideration of the role of education in promoting and supporting primary health care.

The key role of primary health care in the strategy, as the most important part of a country's comprehensive health care system, justifies a major diversion to it of a country's resources, including educational resources. It is for this reason that the main continuing-education effort must be directed at primary health care.

If it is accepted that primary health care means making the fullest and most economical use of resources to improve health, WHO and national health authorities have to consider what this means in terms of the basic and continuing education of primary health care staff. Primary health care has to be a scientifically sound, socially acceptable form of health care related to people's needs rather than only to the interests or concerns of the health professions, and the educational system for health personnel has to reflect this. It depends upon the full participation of the public, individually and collectively, in exercising responsibility for its own health, and on the collaboration of the non-health sectors with the health sector in assuring the physical and social environmental conditions that will promote health; this has likewise to be reflected in the educational system. Primary health care thus has to be distinguished from primary medical care, which, however, is an important part of it. Another essential feature, with important educational implications, is that it must be adequate, accessible, and acceptable to all sections of the community. One implication of this, particularly for developed countries already well covered by primary medical care, is that special attention must be given to vulnerable and high-risk groups: the system must extend its direct health care services to such groups rather than wait for them to approach it. How health care services are reorganized to permit this kind of access will vary among countries, but it cannot be dissociated from the other elements of primary health care and must be reflected in basic and continuing education.

It has been estimated that in the European Region about 75% of health care is lay care, about 20% is provided by primary care professional workers, and 5% at the secondary and tertiary care levels - so-called high technology medicine. Primary health care must be supported by the secondary and tertiary levels of health care so that it can provide essential care on a continuing basis. This implies in most countries a fundamental change in the relation between primary care and secondary and tertiary care, and the need for each country to study carefully how, particularly, secondary care can best play its role vis-à-vis the primary health care system, and be assisted by continuing education to do so.

Dr Wojtczak referred to the three main components of the regional strategy: the promotion of lifestyles conducive to health, the reduction of preventable conditions, and the provision of adequate, acceptable and accessible health care services for all. In addition, the Regional

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[a] The Province of Imperia covered the board and lodging expenses of 20 of the participants.

[b] Alma-Ata 1978: primary health care. Geneva, World Health Organization, 1978 (Health for All Series, No.1).

[c] Primary health care in Europe. Copenhagen, WHO Regional Office for Europe, 1979 (EURO Reports and Studies, No. 14).

Committee had asked that another component be included, relating to the reduction of poverty by various measures, since, although this is a matter primarily of national policies, poverty has a considerable bearing on health. The strategy includes also support measures to primary health care, mainly health services research, and education and training. The Seminar had to consider continuing education in this support role.

In designing national strategies for health for all, and the use of the primary health care approach, countries will have to take account of certain facts about health manpower. One is that, in general, in European countries there is an oversupply of physicians, even to the extent of unemployment among medical graduates in some countries. There is the problem, in relation to the manning of health services, of over-specialization particularly in medicine; it derives from increasing scientific divisions of disciplines without regard to practical needs of health services, and leads consequently to an uneconomic use of manpower. Similarly, there has been in Europe a proliferation of categories of health manpower, upwards of 150, all tending to develop independently, with their own technologies and special interests, and not particularly responsive to the varied and varying needs of health services or interests of consumers.

To a great extent, therefore, for the best and most economical use of manpower resources in the cause of health, European countries have to take a very critical look at these manpower problems and at the educational systems that produce them. The need to orient medical and nursing education, as well as that of other health professions, towards primary health care, to strike a better balance between it and high technology medicine, has now become pressing if these professions are to realize their great potential for primary health care and "health for all". In this Seminar the focus was on the continuing education component of health professional education: how, by means of continuing education, can health practitioners and all others concerned with primary health care obtain the new orientation and acquire the new skills and competencies that will equip them for the necessary teamwork for better health? This demands new ways of using continuing education, ways of applying well established but generally ignored educational principles and methods in support of primary health care.

The San Remo Seminar marked for the WHO Regional Office for Europe the beginning of a new phase in its promotion of continuing education of health personnel. Previous activities[a,b,c,d,e] had covered exhaustively principles, purposes, organization, methods, shortcomings and other aspects of continuing education for health personnel and there is no need for WHO to go over that ground again. Results, in terms of application to national health-related continuing education systems, have been meagre. Now, however, there is a very definite goal to which the education and training of health personnel has to be oriented. The commitment of countries of the Region to health for all by the year 2000, and to primary health care as the key approach to achieving that goal, cannot be realized without very substantial support from continuing education. The generally prevailing methods of continuing education in the European Region have almost no contribution to make in this respect. WHO, in cooperation with countries, has to give special attention now to promoting continuing education in a form that health authorities can use flexibly and with discrimination to promote and support primary health care. Countries must begin that process by spelling out the particular form that primary health care will take in each country and the resources they will apply to it. Only then can education begin to function as a support measure. The European regional strategy document is a statement of policy and method from which can be derived principles and guidelines for organizing a continuing education service in support of primary health care. The Seminar was the first opportunity for a group of European educators of health personnel and of others concerned with primary health care and continuing education to carry out such an exercise.

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[a] WHO Technical Report Series, No. 534, 1973 (Continuing education for physicians).

[b] Relevance of educational planning to health problems: report on a Working Group. Copenhagen, WHO Regional Office for Europe, 1976.

[c] Continuing education of health personnel: report on a Working Group. Copenhagen, WHO Regional Office for Europe, 1977.

[d] Continuing education of health personnel as a factor in career development: report on a Working Group. Copenhagen, WHO Regional Office for Europe, 1979 (EURO Reports and Studies, No. 6).

[e] Continuing education of health personnel and its evaluation: report on a technical discussion. Copenhagen, WHO Regional Office for Europe, 1980 (EURO Reports and Studies, No. 33).

Professor C. Iandolo, Vice-President of the European Academy for Continuing Medical Education, in his opening address warned against a tendency to ascribe shortcomings of health care services exclusively to lack of professional competence. Many other factors had to be corrected or conditions satisfied, without which even highly competent health professionals could not function adequately. Laws that obliged health care practitioners to attend courses though the necessary educational resources were lacking, or health service deficiencies other than lack of competence of medical or nursing practitioners not attended to, could only bring continuing education into disrepute.

Besides the need to reorient technical staff to the primary health care approach, Professor Iandolo referred to the need to train health administrators and managers in the new approach. An important aim of continuing education must be to contribute to such standards of organization and effectiveness of primary health care services as will enable primary health care teams to satisfy communities' needs with much less recourse to the specialized clinical services than occurs at present. An efficient and cost-effective use of continuing education demands an organization and a methodology that can meet the educational needs of multidisciplinary teams at the place of work and in respect of actual health problems.

3. Competencies and skills for primary health care

3.1 The method used by the Seminar to identify PHC competencies and skills

The purpose of the Seminar was to determine from the functions and tasks that comprise primary health care in the European Region, and the corresponding competencies (or combinations of skills) that PHC will need, what should be the characteristics of a continuing education system or service which health authorities could use in a systematic way in support of PHC. Since the regional strategy document is a statement of the main groups of problems that PHC in the European Region is to be designed to reduce, and an outline of the strategies that health authorities are expected to apply to their reduction, the document was used, in an abridged form (Annex 1(a)), as the main working paper of the Seminar; participants drew also on their own knowledge and experience of the health-care and health-service problems of their countries.

The first working session of the Seminar was given over to an explanation of the regional strategy and of the nature and scope of primary health care, as a background to the work on the role of continuing education in support of primary health care. Participants then had an opportunity to obtain clarification on various aspects of the strategy and to relate it to conditions with which they were familiar in their own countries. The study of the problems for which the strategy was devised was continued further in the first group sessions when participants were assigned to four groups according to the classification of problems used in the strategy document, viz., problems related to lifestyles, problems related to the physical and social environment, and failings in the health services (two groups). Each group was given the task of listing, within the category assigned to it, typical problems and their different elements and dimensions. The outcome of each group's discussion was then presented to, and further elaborated in, a plenary session. A summary of this part of the work of the groups is attached as Annex 2.

The groups were then assigned according to the three components of the regional strategy: the promotion of lifestyles conducive to health, the reduction of preventable conditions, and the provision of adequate and accessible health care services for all. Each group analysed one or more typical problems of those it had listed, in order to derive the PHC approach to its reduction and thence to identify the functions or tasks of PHC teams that this approach implies, and the corresponding new competencies and skills they will need. The groups also indicated some of the changes needed in the structure and organization of health care services, and in educational systems for health personnel, in order to permit the use of the PHC approach and the exercise of the new competencies it demands, and without which continuing education cannot be expected to have a significant impact.

From the output of this group work and its further elaboration in plenary sessions the groups derived the characteristics of a continuing education which would meet the educational needs they had identified and accord with the main features of PHC: the assumption by communities, families and individuals of responsibility for their own health; multisectoral cooperation in health promotion and disease prevention; extension of health care coverage for underserved or vulnerable groups; and appropriate technology for health. The characteristics of continuing education included its organization as a system or service, its relation to the PHC services and to other parts of the educational system for health personnel, its functions and methods.

Since all four groups found that, in general, the three components of the regional strategy called for the same range of new competencies for which continuing education would be needed, their conclusions are summarized in the following paragraphs.

3.2 The new competencies and skills for primary health care

The essential role of community responsibility for its own health, which PHC is intended to promote and support, requires a decentralized, localized approach which will vary with physical, sociocultural and economic conditions, with the nature and degree of community involvement and multisectoral cooperation in the health care effort, with attitudes and traditions of the health professions, and with other factors. PHC teams must be able to react and adapt to such circumstances rather than impose stereotyped forms of health care. It follows that they must, to a great extent, be able to identify their own educational deficiencies in relation to the demands of the local situation, thereby determine their own educational needs, and take a considerable degree of responsibility for their own learning.

The multifaceted nature of PHC requires teamwork, which must be multidisciplinary within the health sector, and multisectoral. The best use of all other PHC skills will depend greatly on skilful team functioning, and in this respect leadership and supervision are crucial. The possibilities for joint health action on the part of the health and other sectors opened up by PHC, to which useful contributions can be made by many social sectors, both governmental and voluntary, call for high standards of teamwork competence on the part of the nuclear PHC team since, for one reason, the contributions that "outsiders" can make to health protection will often be just as essential as those of health care workers, and this must be recognized by the PHC team. With regard to community health and primary care in the European Region, there are few models or little experience on which to draw for purposes of either team development or continuing education for team development; primary care teams, of which there is a growing number in some European countries, cannot often be said to function as teams or to provide more then conventional primary medical care.

There are instances of primary medical and nursing care practitioners coming together with social welfare staff to learn from one another how to function in an integrated way in respect of patients/clients and families whom they serve in common, sometimes using for learning purposes instances of obviously unintegrated and inefficient ways of providing services. This suggests that, at least at an elementary level of team functioning, where different kinds of service are being provided to the same families or communities, team leaders and supervisors should be able to recognize deficient team functioning and take appropriate action. This is a problem also for PHC manpower management: those responsible should be able to apply criteria of team functioning in the selection, assignment, training, and performance evaluation of PHC staff.

Apart from teamwork skills such as supervision and leadership, the new operational competencies identified can be classified as (i) those needed to keep the PHC team and its population informed of their health problems - their incidence, prevalence, distribution, severity, effects - and of progress in controlling them, and (ii) those needed in performing direct health-care and related or supporting functions. The first group includes mainly epidemiological and sociological skills and related informational, statistical, and communication skills. The second group, apart from the conventional health-care skills, are mainly educational, communicational, organizational, managerial, and supervisory skills.

Such a listing and classification of competencies and skills must be complemented by reference to the conditions in which they are to be applied, to their purposes, and to the level of competence demanded by the functions and tasks of PHC teams. The conditions in PHC include the exercise of community responsibility for health, the cooperation of non-health sectors, and the balancing of clinical/medical care with prevention and health promotion by a consistent effort on the part of all collaborating sectors to deal with causes of disease and ill health in lifestyles and unhealthy environments. Consequently, demands on PHC teams will vary from one community to another, and the needed combinations of skills and different levels of skills will vary accordingly.

Examples of competencies which the primary medical practitioner will need are: how to deal with patients' psychosocial problems without "medicalizing" them; how to combine clinical care with an epidemiological approach to disease control; how to take part in a concerted national educational campaign aimed at specific target groups in respect of litestyle problems such as smoking, alcohol abuse, and unhealthy diets; how to practise secondary prevention by adopting methods of practice that facilitate early diagnosis of chronic diseases; how to stimulate PHC action by non-health sectors in the interests of vulnerable groups.

Epidemiological competence in PHC was described as more a "way of thinking" than the use of specialist epidemiological methods, or as being able to employ a public health approach, or "field epidemiology", in health care in conjunction with clinical care. Participants referred to the difficulty or impossibility of medical practitioners applying this kind of competence when they are

remunerated for specific services or items of service. However, even where an epidemiological approach to health protection in primary care seems feasible and, as in the United Kingdom, where almost the total population is listed for primary medical care purposes and age-sex registers have been established, the potential of the epidemiological approach to health protection and to the reduction of inequalities in health is not being realized. Competence in this respect is basic to PHC, as well as a structure of health care services which permits its application.

Educational competence is another set of skills basic to PHC, mainly for health education of the public but also to some extent for professional education since it is likely that some members of PHC teams will have professional education functions. One important aspect of educational competence is that needed for self-education including, as stated above, being able to identify one's own educational deficiencies and needs in relation to the communities being served, and taking responsibility for one's own learning.

The role of health education in PHC in the European Region, especially in the promotion of lifestyles conducive to health, is discussed in a WHO document of which an abridged version was provided to the members of the "lifestyles group" at the Seminar (Annex 1(b)). It indicates the main aims of health education in PHC and suggests in general terms the competencies needed to achieve these aims. An important issue for countries to resolve, before definite decisions can be made about competencies and training needs, concerns the roles of professional health educators and of health professionals who are not specialist health educators. The extent to which communities and families exercise responsibility for health and for self-care will influence also the demands that will be made on health education.

With regard to lifestyle problems the health education competency expected of a PHC team must be that which can set feasible and worthwhile objectives and produce the planned degree of behavioural change. A key educational skill for the PHC team, therefore, must be that of ability to evaluate its health education effort against the degree and consistency of behavioural change produced. Specific health education skills identified by the group in relation to a lifestyle problem (smoking) included those of classifying problems or dimensions of problems according to feasibility, identifying and selecting target groups according to degree of risk, carrying out epidemiological surveys with community participation and disseminating their results to produce a planned effect.

4. Continuing education in support of primary health care: conditions, organization, methods

From the exercises that the groups carried out in relation to the identification and analysis of problems, tasks, and skills they derived the following characteristics of the organization, functioning, and methods of a continuing education service, and of the relations between such a service and a health care service. This series of characteristics can be regarded as a checklist of conditions and requirements which organizers of continuing education can use when appraising existing educational programmes or planning new systems or services. Also they suggest studies of feasibility, cost-effectiveness, methodology, and other factors, in which WHO and Member States can collaborate.

(1) As a condition for the effective use of continuing education in support of PHC the nature of PHC and its scope and objectives must be made clear to the health professions and to the public, and distinguished clearly from primary medical care.[a] It must be a widely accepted and a highly valued and respected mode of practice; otherwise, continuing education or any other support measure cannot be productive. Acceptance by the health care professions will mean substantial changes in organization and methods of practice from existing predominantly primary medical care practice but, while it will be the task of continuing education to facilitate those changes, the basic steps to restructure the services must first be taken by health authorities and the health professions.

At present neither the public nor important organizations such as trade unions or political parties are aware of the goal of health for all or the primary health care approach. Means must be found of publicizing and popularizing the goal and the approach, in view particularly of the essential part that individual and collective responsibility for health has to play in primary health care. Communities, families, and individuals must be well-informed about the

[a] See Kaprio, L.A. Primary health care in Europe Copenhagen, WHO Regional Office for Europe, 1979 (EURO Reports and Studies No. 14) See Section 3 for a discussion of the problems of distinguishing primary health care from primary medical care in the European Region.

nature of their health problems, and particularly their social and removable causes, and of the stresses and health hazards to which they are subjected, so that they are motivated to assume responsibility for taking action to protect their own health.

(2) There cannot be a uniform system of primary health care for all countries. It has to develop from what exists already. Continuing education is one of the means that a health authority will have to use to modify a service gradually in the direction of primary health care and to integrate networks of services - both health and health-related - into a primary health care system. It may be considered as a means by which PHC teams learn and improve the skills for working with their communities to define and formulate their common health care problems and solve or reduce them; it is not a matter of "filling the container" of health professionals with knowledge or information.

(3) A national continuing-education system as a support measure to primary health care would have two main roles. One would be, as part of a systematic implementation of national policy, to "inject" into a national PHC system new skills and perspectives, mainly educational, epidemiological, and sociological, and to promote team development. This would need to be undertaken in association with various non-educational measures - legislative, organizational, and others - without which education would have little impact on health care practice. The other, at the local level, would be to respond to specific education and training needs of PHC teams; this could include assistance in assessing competence and performance, and in determining causes of sub-standard performance or of failure to achieve health care objectives, advising on methods of learning new skills or organizing training activities when necessary, and helping teams to develop and function as teams.

(4) Participants considered that a continuing-education service office (CESO), responsible in a district or region for meeting the educational needs of a number of PHC teams, would best meet organizational needs. It could function as the main educational resource, or the resource agent, for the local PHC services, providing some educational services direct and others indirectly from other educational organizations and from other parts of the health services; it would also help to develop the teams' own educational resourcefulness, including their capacity for self-learning. It would have the educational-evaluation functions of training team members to carry out internal evaluation, including self-evaluation, of competence and performance, and of participating in the evaluation of the impact of the PHC effort, equivalent in some respects to an evaluation of the continuing-education service itself. Besides its evaluation functions it would carry out educational research and have the capacity to draw on and apply the findings of such research carried out elsewhere, especially in relation to adult education.

The continuing-education service should be highly skilled in the use of educational technology so that it can make available the needed advice and expertise on all aspects of educational planning, from the assessment of professional competence as a basis for identifying educational deficiencies and needs to the evaluation of the impact of education in relation to the objectives of the health services. It should be able to use education in a discriminating way so as to ensure that educational resources are not misused in trying to solve problems for which other solutions would be more apt or for which other solutions are indicated besides an educational one.

(5) A continuing-education service can be part of a health service or of a separate educational service; or it can be an autonomous organization with clearly defined responsibilities towards health services and professional bodies. Clearly, a continuing-education service which is independent from the health service in its structure and financing can undertake other activities besides meeting specific PHC needs, but as a support measure its relation to the health service must be that of a partnership, responding to identified needs of the service and of health teams rather than dictating the content and form of its educational services.[a]

(6) In the same way as a primary health care service at a local or district level will take the form of a coordinated, articulated network of previously uncoordinated facilities and services, it is likely that a continuing education service in support of primary health care will also often take this form. To establish and maintain such a network of educational resources is a basic step, and one that will require considerable effort, in organizing a system of continuing education

[a] Relevance of educational planning to health problems: report on a Working Group. Copenhagen, WHO Regional Office for Europe, 1976 (Sections 2.2 and 3.2).

for primary health care, since most institutions or agencies on which a continuing-education service can draw have grown in isolation from one another and from the health services that they will be supporting.

(7) A national continuing-education system will have its own different levels of functioning, interrelating with one another, its peripheral level being supported by its regional and national levels. Their respective responsibilities should be clearly specified, and as far as possible their functions in support of primary health care decentralized to the health service level where they are most needed and can be used to best effect.

The PHC team in its own district, in close contact with the local community, will be concerned with local health problems and their social and other dimensions (or the health manifestations of such problems as unemployment or poverty or occupational hazards). One of the tasks of continuing education will be to help the team to see the same problems in their regional or national perspective because this may, for example, modify how it will deal with them locally or affect the priority order in which it will try to solve them, influence the contributions of other sectors to their solution, or determine the demands that the PHC team will make on a continuing-education service.

(8) The organization of continuing education in support of PHC should permit national health policies to be reflected in peripheral continuing education services, and it should permit also the experience of peripheral education services to be communicated to a central authority, particularly so that successful educational experiences may be propagated.

(9) In view of the wide scope of primary health care (as distinct from primary medical care) and especially its multisectoral dimension, and the explicit responsibility of governments for protecting their citizens' health - particularly that of the poor and underprivileged, who are most in need of measures to promote health and prevent disease - the responsibility for ensuring the quality and coverage of primary health care, and of continuing education as one of its main support measures, must rest ultimately with governments. Also they must ensure that just as access to primary health care is assured to the whole population, so also must access to continuing education be assured to the entire primary health care system.

(10) Countries may need to review legislation and regulations concerning continuing education because the official concept of continuing education may not be consistent with its role as a support measure to PHC. There may, for example, be legal obstacles to the systematic approach to continuing education to meet health care needs as outlined by the WHO Working Group on Continuing Education of Health Personnel.[a] Thus, in one country, funds are not provided for continuing education of any group of health workers of fewer than ten salaried staff. In a number of countries, continuing education is very formalized and, as almost everywhere in the European Region, exclusively profession-linked. These and other instances of incompatibility between the concept of a health-service-linked continuing-education service advocated at the Seminar and the established view of continuing education call for a profound review and revision of conventional educational concepts; to begin with, health and education authorities need to lay down criteria against which existing and new systems of continuing education should be evaluated for impact on health care and health services, and the educational systems should in all cases provide this evaluation function as an essential component.

(11) Bureaucratization in health services may hinder innovation in both health care practice and continuing education. In particular, it is likely to present obstacles to community participation and intersectoral cooperation in solving local health problems, and to unorthodox ways of extending health care to vulnerable and underserved groups.

Obviously, bureaucratic procedures that are incompatible with the exercise of community and family responsibility for protecting and promoting health, with multisectoral and multidisciplinary teamwork, and with innovative forms of health care, will have to be reviewed and replaced; a continuing-education service in conjunction with the health service must be able to identify the points at which educational intervention can help to overcome bureaucratic obstacles, and apply the necessary educational measures.

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[a] Continuing education of health personnel: report on a Working Group. Copenhagen, WHO Regional Office for Europe, 1977.

(12) The basic or undergraduate education of health professionals, particularly of doctors and nurses, concentrates almost exclusively on clinical training and the management of the sick, and hardly at all on meeting the health needs of populations. One of the tasks for continuing education therefore, in respect of doctors, nurses, sanitarians and other health workers already in practice or coming into practice, is to redress the consequent imbalance in their competencies. Eventually, if the necessary changes are made in basic education, especially in undergraduate medical and nursing curricula, this task of continuing education will become less pressing.

The community nurse is a pivotal member of the PHC team in that she is usually more closely in touch with the public and more health-oriented than other kinds of health worker, but community nursing represents a much smaller proportion of all nurses than do clinical nursing and its various specialties. A reorientation of basic nursing education in favour of PHC should draw heavily on the experience of pilot studies of PHC teams and of continuing education for primary health care.

Since progressive medical and nursing schools, sometimes jointly, are now incorporating elements of primary health care in their community health teaching and research activities, and this is likely to be a growing trend, it is obvious that it would often be beneficial to a continuing-education service to establish an association with such community health departments, drawing on their training and research experience, and indicating problems that need educational or health services research.

(13) Once a health authority or national government takes steps to implement primary health care, PHC teams will have to be trained in the elaboration and practical application of such basic PHC concepts as community participation, intersectoral collaboration, the extension of coverage to underserved groups, and appropriate technology for health. The application of these concepts in practice calls for special kinds of managerial, organizational, communication, education, and other interactional skills, largely new to primary care. Effectiveness in applying these skills to preventing disease and promoting health should be valued by the professions and the public as much as clinical skill is valued at present, and it will be a central function of continuing education in support of PHC to help teams to develop and maintain this effectiveness.

The elaboration of these concepts for practical purposes can best be done in actual problem-solving contexts because of the great variety of forms they will take in different countries and sociopolitical circumstances. Since there can be no universal pattern or model for the application of these elements of PHC and they will take a great variety of forms in the different countries and sociopolitical conditions of the European Region, their elaboration must be an empirical process which can only take place in actual problem-solving contexts. A continuing-education service must therefore be in a position to respond to educational needs which come to light in local circumstances; consequently it must be problem-oriented, geared to problem-solving rather than to "theoretical" teaching. PHC teams can acquire the combinations of epidemiological, managerial, organizational, communicational, educational, and other interactional skills gradually in the course of their work, with educational assistance; it is inconceivable that these competencies can be learned once and for all in formal educational courses.

Health authorities and PHC workers should not feel intimidated by the list or range of new skills that the PHC approach demands. These skills have to be assessed in relation to the problems with which PHC teams become concerned; in the practical, problem-solving, context it will, in general, be seen that they do not require forbidding degrees of expertise. Certain skills such as those of leadership, supervision, education, and communication will have to be exercised at a high level of competence and it is likely that a continuing-education service will need to be particularly geared to training for such skills, especially because of their potential "cascade" effects. The necessary revaluing of primary care vis-à-vis the secondary and tertiary levels of medical care will depend heavily on the success with which continuing education can assist selected members of PHC teams to develop these skills. It should not be forgotten that the secondary level of health care will have new responsibilities in support of primary health care, which should also be a concern of continuing education.

(14) Logically, in the light of its responsibilities for health care, the PHC service, and the teams that comprise it, should have the primary responsibility for determining their own educational needs, or at least for playing an important part in doing so. These needs are determined mainly on the basis of an assessment of a team's competence for its functions and tasks and of an evaluation of its performance in respect of its health care responsibilities. The health authority should set criteria for evaluating a PHC team's formulation of health-care and health-service problems, and of its objectives in respect of these problems, so that they conform to PHC principles, particularly that they reflect the community's perspectives. These criteria are needed also for the design of continuing-education programmes. A continuing-education service should be able to make available to a PHC service and its teams the skills they may lack for identifying educational needs, and designing training or self-learning exercises or programmes

accordingly; it should also train PHC team members in these skills and provide them with consultant services as necessary since the team should be able to assess its own competence and performance. Teachers or educational programme organizers must guard themselves against the tendency to determine arbitrarily what PHC team members should learn, neglecting to assess the team's educational needs in relation to its health care functions.

(15) One element of a continuing-education system for PHC should be, in each PHC team, a designated team member responsible for educational tasks, maintaining liaison with the continuing-education service, who would take the initiative in assessing educational needs of the team and finding ways of meeting them. A continuing-education service would be responsible for training selected team members for this function.

(16) Research - operational and educational - may be needed to ascertain the true nature of problems to be solved and the best mix of functions, tasks and personnel, both within and outside the health sector, that would solve them. This should be a joint function of the educational and the PHC services, and also one for which PHC teams will need to be trained.

Good quality information is needed to show the points in the chain of etiology of a health problem where intervention can produce worthwhile effects. Good epidemiological and sociological data are particularly needed, and they must be well interpreted so that health care problems may be identified and formulated in comprehensive terms which will permit an attack on their sources rather than only medical or nursing care. In such a complex context a continuing education service must be able to assess the validity of the problem formulation that a primary health care team or service has made, and of the tasks and skills that it has identified as those that are needed to deal with the problem.

(17) The community's perspective of a problem or of the means of solving it may result in PHC teams having to undertake tasks for which they have not been trained; this is one respect in which the community may take part in identifying educational needs both of the nuclear PHC team and of others who enter the team for a specific purpose. An important function of continuing education will be to train PHC teams in ways of motivating communities to take action in respect of health problems and supporting such action. Teams will have to learn how to apply the principle of maximum delegation of responsibility for their own health care to families and communities, and to promote and support the exercise of such responsibility.

(18) As a support service to PHC, continuing education has to be available to all categories of primary care staff. In view of the wide scope of PHC and the essential roles in it of non-health sectors and the community in general, primary care workers will often include professionals from non-health sectors and members of the public who undertake to take part in PHC activities. By focusing on the PHC team rather than on separate disciplines, and on problem-solving rather than didactic teaching, a continuing education service will ipso facto be concerned with all categories of team member. Health professionals must be open to educational support from non-health resources, particularly in learning from joint problem-solving with non-health-sector workers. Multidisciplinary continuing education for PHC need not preclude profession-linked continuing education whether for PHC or for other purposes, organized, for example, by medical or nursing associations for their members, or by postgraduate medical institutions as is common in eastern European countries.

(19) The composition of PHC teams can vary considerably according to the nature of the problems that they set out to solve. It is usual to consider the PHC team as composed of doctors, nurses, social workers, and other professionals and non-professionals specifically assigned to PHC duties. However, in relation to problems of lifestyles and of social and environmental pathology, and to failings of health services, the team at any particular point or in relation to any particular problem will have to include or employ the skills of various professionals and other workers from other sectors as well as members of the public. Members of the nuclear PHC team can be at the same time members of different PHC teams concerned with other problems.

This variability in the composition of PHC teams has obvious educational implications; continuing education can be used, for example, to better enable personnel from different sectors to work together towards common health objectives, or to provide health professionals with the skills of cooperating constructively with members of the public or community representatives. Another implication is that a PHC team need not always call on an educational service in order to obtain new skills. It can sometimes "import" them from other sectors. Often those who need to acquire new skills can do so in the course of their work if they are well supervised, or from one or other member of the basic or expanded team responsible for dealing with a particular problem. It can also happen that defective teamwork is not amenable to formal educational remedies but that people from different sectors, for example, who are motivated to solve a problem in coordination learn to do so by becoming aware of the problem and making an effort to solve it.

(20) The promotion of team development throughout the whole PHC service of a country - helping each team to establish a team identity and to function as a team - is likely to be the area that will make the most formidable demands on continuing-education services. Health and education authorities should not underestimate the skills which such a service must be in a position to supply and the difficulty in obtaining the services of qualified educators. They include as a major element psychodynamic group-skills as well as organizational, managerial, informational, and evaluation skills, and the ability to guide team members in acquiring the necessary teamwork skills in the context of the health problems with which they are concerned.

A continuing-education service should be able to distinguish different levels of team functioning, from the grossly inadequate to the excellent, and to establish indicators of team functioning at such different levels, as well as criteria which teams at different levels of development could attempt to meet. In this respect continuing education should be closely associated with PHC manpower management, which should see PHC team development as one of its main objectives.

(21) The practice of primary health care in its modern sense, based on teamwork, with inter alia its emphasis on community participation and the exercise of individual and collective responsibility in health matters, and on the collaboration of public and private sectors other than the health sector in the prevention and promotion of health, is largely new ground for both health care and continuing education. Some European countries have made progress in applying the health team concept, and there are health care teams in which various aspects of the physical and social environment are represented. However, in many countries of the Region there are formidable obstacles - structural, organizational, health-professional, legislative - to the kind of teamwork that primary health care demands and the concept of the community health centre as its operational base,[a] as well as the expansion of the PHC team to include members of the public for particular purposes.

For these reasons an empirical approach is indicated to continuing education for team development, with the proviso that sound educational principles be observed in devising educational support measures. This could begin with pilot studies of the functioning of health teams and of continuing education for team development, in ordinary health care settings in different milieux with different staffing patterns and practices; particular attention should be given to ways of overcoming or removing the common obstacles to teamwork in health care. Three types of setting could be used for such studies:

(a) health centres with an established primary health care team as is found in Finland and in the United Kingdom, for example;

(b) places where primary health care teams are being established for the first time as in, for example, Spain, Portugal or Greece;

(c) atypical primary care settings such as are found in the polyclinic system of certain eastern European countries.

(22) One of the conditions which must be met before a continuing-education service can make its optimum contribution to team development and team functioning is that the team's roles and functions be well defined. This is primarily a matter for manpower planning and management on the part of a national health authority, but the team also, vis-à-vis its approach to a health problem, must make explicit its functions and tasks and those of its individual members.

There will often be an overlap of functions and tasks among some members of the PHC team; these overlaps must be made explicit and an undue rigidity as regards "rights" or demarcation of functions avoided. However, care should be taken lest clinical tasks be overvalued at the expense of health promotion and disease prevention; a continuing-education service can play its supporting role particularly in this respect, to give health promotion and disease prevention their due place in PHC.

(23) With regard to health education particularly for the promotion of lifestyles conducive to health, a condition for the effective use of a continuing-education service must be that the health educators' roles and functions and expected level of competence, especially those of the health

[a] Primary health care in Europe. (EURO Reports and Studies No. 14) Copenhagen, WHO Regional Office for Europe, 1979 (Section 4).

worker who is not a professional health educator, be clearly defined. A continuing-education service should be able to contribute to this definition, to provide the necessary educational support to both the professional health educators and the other health workers, and to contribute to evaluating the impact of health educational efforts. In some respects, both health education and the dissemination of health information to the public will overlap with continuing education, since the attainment of some health-promotion and disease-prevention objectives will depend on joint action by communities, politicians, and administrators and managers of health services and of other related services with PHC functions.

5. Conclusion

The stated aim of the Seminar - to determine from an analysis of the Regional Strategies for Attaining Health for All by the Year 2000 what should be the characteristics of a continuing education service in supporting PHC - had two main elements: the process by which those characteristics should be derived, and the outcome of that process, viz., the characteristics of continuing education in support of PHC. Of these two elements the process is the more important because, if countries are to have effective continuing education in support of PHC, those who make the educational plans and decisions must first master the process. The work of the groups in the Seminar was a simulation, however imperfect, of that process.

The outcome (section 4 above) is a series of statements of conditions and needs which the organization of a continuing-education system in support of PHC should be designed to satisfy, once a country goes ahead with reorienting its PHC services towards the model implied by the regional strategy. How these conditions and needs will be reflected in actual organizational forms in different countries and localities will have to be elaborated within countries. This will demand in turn a certain competence in educational planning on the part of both the health and the education services, including the ability to evaluate the educational process and its impact.

The primary lesson of the Seminar was that educational decision-making has a logic which depends on an analysis of the work to be performed and the circumstances in which it will be performed, the previous educational background and experience of those who need to be trained, and an informed assessment of the capacity of an educational service to provide the necessary support. A health authority should not accept unquestioningly an educational solution to a problem - at national, local, or institutional level - which has not been derived from a diagnosis, against well-defined criteria, of the educational problems to be solved, and which cannot be shown by evaluation to be achieving the purposes for which it was devised.

Health authorities cannot expect continuing education to make a substantial contribution to primary health care unless they assure the conditions for the exercise of the epidemiological, sociological, educational, teamwork, and other competencies which must be the objects of continuing education in support of primary health care. It would be wrong at the same time to take the view that education can have no useful results before all the obstacles to the practice of primary health care have been swept away. A well-planned and well-directed educational enterprise can have its own dynamic effects on a health service once its intended impact has been spelled out in terms of health care. Despite the primacy of the health care service and the supporting role of education, the educational service should be regarded not as being subservient to the health care service but rather as its partner in implementing the national PHC policy.

Annex 1(a)

REGIONAL STRATEGY FOR ATTAINING HEALTH FOR ALL[a]

The health services are poorly distributed. There are still groups who are grossly underserved and without effective access to health care. The gap between the health standards of different social groups has not been narrowed. Among the wealthier countries of the Region progress has been uneven. It may even be questioned how much credit could be attributed to the health care system. There are countries with infant mortality rates as low as 8 per 1000, while others have rates which are twice as high; some countries have maternal mortality rates as low as 5 per 100 000 live births, while others have three or four times as many maternal deaths, and mortality rates among the middle-aged (41-54 years) range from 370 to 720 per 100 000 population. These differences cannot be explained by levels of health spending, by the ratio of trained manpower or of hospital beds, or any other indicator of health resources.

The health investment of the past 30 years has been devoted mainly to dealing with the health problems which have presented themselves, rather than to preventing these problems arising in the first place, let alone seeking out those at greatest risk. Yet, for many health problems, the curative actions have limited effect. Most important of all, much of the health damage is self-inflicted. In the nineteenth century, countries were slow to respond to the accumulating knowledge that impure water and bad sanitation were decimating the cities of Europe. Now, in the late twentieth century, countries have been slow to find an effective response to the knowledge that critical features of lifestyle and the environment are having major effects on health standards. In both cases, the provision of remedial services is not only a grossly inadequate but also a grossly imbalanced response.

Very significant knowledge about health risks has been gained: the damage to health from cigarette smoking, the abuse of alcohol and other drugs, and unbalanced nutrition is well established, and it is well known that a high proportion of accidents could be prevented. Progress in combating these risk factors has been slow and relatively ineffective, so this is where a major health effort must be devoted over the next 20 years.

Within the health sector the emphasis has been on cure, or more often remedial treatment, rather than on health promotion and health prevention. The mainly curative services have concentrated on secondary and tertiary care, which treat health problems when already well advanced, rather than on primary care in the community where problems can often be prevented or treated earlier and more effectively. The emphasis has been on what health care professionals can do rather than on what people can do for themselves.

To achieve health for all will require a fundamental reorientation of priorities over a period of 20 years. It has major implications for research, manpower training, construction, information systems and evaluation. This reorientation will need to take place against a background of an aging population, social instability, and new lifestyles. The evolution of technology, particularly in energy production, electronics, chemistry and biology will further affect the environment and the quality of life, and more structural changes are bound to occur in industry, agriculture and service occupations. If chronic unemployment continues to grow in some countries, or there are continual changes in employment in others, this is likely to lead to groups with particularly high health risk, and to pockets of social deprivation and relative poverty, leading to psychosocial disorders and social disruption.

What is required is a planned and steady reorientation of the system. More cost-effective ways must be found of doing what is now done and needs to be done, so that resources can be released to do what is currently left undone. This will require:

- less use of costly inpatient care by a further development of day hospitals, outpatient diagnosis, and early discharge policies with the full support of home nursing and other domiciliary services;
- a greater use of generalist care and a more selective use of specialist care;

[a] This abridged version of the regional strategy document was prepared to serve as a working paper for the Seminar participants.

- a more cost-effective use of drugs, diagnostic tests and medical equipment and a more careful evaluation of innovations;
- a greater delegation of selected tasks;
- the promotion of self-care and risk avoidance.

The key instrument for putting the regional strategy into effect is an organized system of primary health care to which all have access. This system of primary health care must:

- be built on the principle of community participation,
- be staffed by a multidisciplinary team,
- be supported by an effective referral system,
- prevent diseases, promote health, care and rehabilitate,
- reach out into all homes and workplaces systematically to identify those at highest risk,
- help people to assume greater responsibility for their own health.

Problems related to lifestyle

Health problems due to lifestyle can be reduced by changes in behaviour. They are, however, the result of deep-seated cultural influences, the exposure given in the mass media to certain unhealthy habits, and the sales promotion practices of manufacturers of products some of which, such as tobacco, alcohol and baby foods, directly affect health. Of major importance is the prevalence of cigarette smoking. Also of great concern is the abuse of alcohol which is an important cause of road and work accidents, can be associated with mental illness and suicide, and plays an aggravating role in several major diseases. The abuse of other drugs constitutes a growing problem. Obesity and unbalanced nutrition are major problems in the more affluent countries while the lack of nutrients leads to stunted growth in the poorer countries. A high incidence of sexually transmitted diseases has accompanied changing lifestyles and sexual attitudes. Lack of physical exercise may well prove to be an important factor in ill health.

The physical and social environment

While concerted action is being taken throughout the Region to improve the environment in which people live, work and take their leisure, there are still problems of gross pollution - particularly of rivers and of the sea. The rapid introduction of new chemicals which affect air, water, food and the working environment has posed new problems of identification of risk, surveillance and control.

There are still parts of the Region which lack the most basic requirements of pure water and effective sanitation, and pockets where overcrowded and inadequate housing are major risks to health.

The Region has been experiencing rapid social change. Certain segments of the population feel alienated from society, dissatisfied with current social institutions, and yet unsure of what should be put in their place. The increased instability of the family creates insecure conditions for children and leaves some people in loneliness. The rapidly growing trend for women to work outside the home has altered the role of the family in providing care to children, the aged and disabled. Furthermore, housing developments of the past 30 years have not been conducive to a sense of community, and large numbers of people live isolated lives in vast suburban estates, having little personal contact with their neighbours. Individuals become more exposed and vulnerable as moral and behavioral rules change and social and economic barriers are reduced, so they must take more responsibility for their own success or failure in the general educational and social system. Social tensions arise from the presence of underprivileged immigrant groups, especially if their norms and ways of living are different from those of the rest of the population.

Failings in the health services

Of critical importance is the availability and accessibility of services. In few countries of the Region can it be said that there is a geographically even distribution of services. In general it is the poorest parts of countries and the poorest countries which tend to be deprived of adequate services, especially for primary care. These are usually rural areas, or deprived city centres - the areas that need health care most.

Social security systems in some countries do not cover important minorities such as the self-employed, and small farmers and their dependants, and may make inadequate provision for one-parent families, the unemployed, and immigrant workers who have not obtained sufficiently stable employment to become eligible for social security benefits.

Unchecked technological development can result in an increase in iatrogenic problems and also leads to an increase in the professional monopoly of health knowledge and a reduction in self-reliance. Medical training is only to a small extent geared towards primary care, family problems and lifestyle counselling, and often excludes teaching on the socioeconomic aspects of health care.

Under fee-for-service payment systems, provision is made to pay for specific medical acts: lifestyle counselling and surveillance are time-consuming yet inadequately rewarded even where specific provision is made for them. Under capitation systems of payment, curative services must, of course, be provided, but the system may not require primary care doctors to provide counselling and surveillance. For these and other reasons, not least the orientation of medical education, the most important personal preventive services are grossly underprovided.

The extent to which public health nursing and community nursing are developed varies widely. In some countries they are integral parts of primary health care teams, in others they work in almost total isolation. In some countries community nurses are independent practitioners paid on a fee-for-service basis. There are often no definite links with domestic help services or with social work services.

Community participation is virtually nonexistent in the primary care systems of most countries. The health services have developed as a service to the population rather than as a service for the population. Users could play a greater role in stimulating what is provided and participate in the key decisions which influence the health of their local communities.

A major demographic change will be a continued increase in the proportion of elderly people. Substantially greater provision will need to be made to deal with the chronic diseases of old age, and services strengthened with the aim of postponing mental and physical degeneration. For people to live socially and economically productive lives for as long as possible, support will have to be provided for elderly people who wish to remain in their own homes and in their own communities. The expected success of preventive programmes will only add to these needs.

There is a risk of growing and chronic employment problems and all the stress and social deprivation which arises from them.

Migrant workers may increase their health knowledge and gain access to better health services, but their living and working conditions may create new health and psychosocial problems.

There is a particular need to improve the health of the underprivileged, because pockets of poverty correspond to high concentrations of health problems. The struggle against poverty and social deprivation is an integral part of the battle for better health, in developed as well as in developing countries. In addition, special efforts are needed to raise the quality of care provided to certain groups of patients who tend, in some countries, to be relatively neglected - particularly the mentally ill, the mentally retarded and the chronic sick.

A strategy for achieving health for all

Underlying principles

To be effective the strategy must be developed on the underlying principles of equity, prevention, participation and cost-effectiveness. Health resources must be distributed equitably, and according to health needs. A new emphasis on prevention is required because underlying the health problems of the Region are problems of lifestyles, the environment and poverty. Community participation is essential because the problems are of such a nature that not only public understanding but also public support are vital if they are to be overcome. Thus, an essential part of the strategy must be to get people to take greater responsibility for their own health. The constantly rising levels of education throughout the Region provide a firm foundation for this approach. Finally, attention must be paid to cost-effectiveness and relevance, for only if a better use is made of available resources can room be found for new developments. The level of technology used for each task should be no more and no less than that task requires.

The most formidable task is to change behaviour and attitudes in matters of health. One part of this task is to change lifestyles. This is largely uncharted territory. The second part is to change attitudes to the health care system. Too often it is regarded as if it were a chain of workshops capable of repairing or replacing any part of the body, whatever damage its owner has done to it. The message which must be put across is that some damage is irretrievable. There are finite limits to the potentiality for medical intervention.

The strategy

The strategy consists of three main elements: the promotion of lifestyles conducive to health, the reduction of preventable conditions, and the provision of care which is adequate, accessible and acceptable to all. In addition, in accordance with a Regional Committee decision, it is to include reduction of poverty by various measures.

Healthy lifestyles

Individual and community lifestyles conducive to health must be promoted. The first approach is the development of individual awareness of health risks and the changes in behaviour needed to avoid them and reduce exposure to self-imposed risks. This awareness must be developed early in life.

Intersectoral approaches are needed to improve social and economic conditions which influence choice of lifestyle. These conditions include job opportunities, working and living conditions and social networks.

Self-imposed health risks, such as alcohol and other drug addictions, smoking, unbalanced nutrition, sexually transmitted diseases, early pregnancies and other disruptive elements of lifestyle can be reduced by information and education. Legislative and regulatory controls may also be needed, however, especially in the fields of illegal imports, food safety, pollution, and other risk factors in the environment. Efforts should also be made to develop new preventive measures and community-based means for cure, rehabilitation and social integration.

Reduction of preventable conditions

Mothers and children are the most important target group for strengthening the basis for achieving health for all by the year 2000. Emphasis should be put on comprehensive early detection of defects and risk factors.

More strenuous efforts are needed to reduce accidents and their consequences. These include innovative approaches to public education, road construction, traffic regulation, the regulation of the safety of vehicles, the regulation of safety at work and in the home, and tighter regulation of the safety of consumer goods.

The production of food of adequate quality is of critical importance in developing countries, where measures may also be needed to ensure that the lowest income groups can get enough food. Other measures will include educational campaigns to discourage obesity and encourage balanced nutrition and breast-feeding, and regulations concerning food safety.

The reduction of exposure to environmental risks will need intersectoral approaches to improve the identification of hazards and to implement more effective controls.

The provision of adequate and accessible health care for all

According to the Alma-Ata Declaration primary health care accessible to all, and with secondary and tertiary support, is the key instrument by which health for all may be achieved. In many countries of the Region the implementation of the underlying principles over a period of 20 years will involve major changes in professional practice and the organization and financing of health care. Community-based systems should be developed, with an adequate redistribution of resources towards services relevant to the needs of the community and the family. Priority will be given to promotion and preventive activities, making use of self-help and adequate self-care. More attention will be devoted to the humanization of health services. The respective tasks of members of the health team and lay people will have to be redefined.

Underserved and high-risk groups should benefit from special services integrated into the current health system and social networks. This concerns especially the elderly, the mentally ill and mentally handicapped, the disabled, migrant workers, as well as people living in remote areas with few facilities.

Support measures

To carry out the strategy, planning and management will need strengthening in most countries, and in some countries there will have to be major changes in the organization and financing of the whole health care system. The changes will need to be planned in conjunction with representatives of providers and of users at all levels, and incentives will be needed to reorient the system and to ensure an appropriate use of staff and technologies.

Research will need to be reoriented in line with the strategy, and much of it will be multidisciplinary. There will have to be more research into problems of the environment; in sociology as applied to health, including the effect of lifestyles; and in health economics. Much more research is also needed on the functioning of health care systems. Information systems will need to be improved to support the planning, management and evaluation of health programmes, and the information gathered shared with providers and community representatives at every level.

From the strategy can be derived the need for specific categories of skilled manpower. The number of personnel with particular training should not be allowed to determine the strategy, as has tended to happen in some countries in the past. Of special importance will be training for work in the multidisciplinary teams of the primary health care system at local level. Much of this training should be multidisciplinary and community-oriented and undertaken in association with local services. It will involve a fundamental reorientation of medical and nursing education.

Annex 1(b)

REGIONAL PROGRAMME IN HEALTH EDUCATION AND LIFESTYLES[a]

At its thirtieth session the Regional Committee for Europe, in endorsing the regional strategy for attaining health for all by the year 2000, stressed the importance of health educational activities, which are very closely associated with two of the main thrusts of the strategy, i.e. promotion of lifestyles conducive to health and reduction of preventable conditions.

We live in societies that too often damage health rather than promote and protect it, and inequalities and social differences in health are increasing rather than diminishing. The Regional Committee at its thirtieth session called the Regional Office's attention to the area of poverty and health as a special focus of its work.

The regional strategy document points out the high relevance of health education for the promotion of lifestyles conducive to health and expands the notion of health education in accordance with new developments in the field.

One of its main concepts is that of participation of the individual in health care as a competent actor in a community setting, rather than by passive compliance. Health education and information can be developed along three main lines:

- raising individual competence and knowledge about health and illness, about the body and its functions, about prevention and coping;
- raising competence and knowledge to use the health care system and to understand its functioning;
- raising awareness about social, political and environmental factors that influence health.

Health education should use innovative educational approaches and technologies; should be geared towards community action and lay participation; requires a multisectoral and multidisciplinary approach; and must take account of the social and environmental factors that influence health decisions.

Virtually every programme seeking to protect or improve health status has social and behavioural aspects, to which health education must be directed. Four conceptual problems can be identified, as follows:

1. Health prescription versus health promotion

Health achievement requires a conscious effort on the part of the individual, the community and the state. The orientation towards primary health care should be seen as an orientation towards health not disease, towards health promotion rather than cure of already well-advanced problems. Whereas a health prescription approach could well be dealt with in one system, i.e. the medical care system, a health promotion approach depends on the coordinated efforts of all units of society. An appropriate example would be smoking policies, where a decrease seems possible only if the call for individual nonsmoking behaviour is accompanied by socially credible promotive public action for healthy lifestyles. WHO European regional programmes in smoking and health, drugs, alcoholism and mental health are increasingly concerned with health promotion and many of the health education programmes are starting to reflect similar reorientations.

2. Individualistic behaviour modification versus a systematic public health approach

The central focus of health education has tended to be the individual and the family with regard to combating harmful lifestyles. This strategy has often been accused of "blaming the victim", as it calls for individual change, whereas often the responsibility seems to lie more with forces outside the individual's scope of influence. The problem of sewage in drinking-water was not solved by ignoring the environment and appealing to individuals to boil water. It is the

[a] An abridged version of a document prepared for the WHO Regional Committee for Europe, 1981; it was abridged to serve as a working paper for the Seminar participants.

improvement of certain environmental and social conditions that has led to overall reduced mortality in the last 100 years. It seems necessary to reconsider systematic approaches that credibly link political, social and individual responsibility in maintaining health. Lifestyles and responsibility are as much products of social and cultural factors as concepts of health and illness. Definitions of what constitutes healthy behaviour need to be reconsidered in this perspective.

3. Medical orientation versus lay competence

The primary health care competence of individuals and families is a notion as yet little understood or appreciated. Self-care programmes could transfer many technical skills to lay persons while at the same time making use of traditional health practices in the family. New forms of cooperation between professional and lay health care could be developed, thus opening the health care system to a much wider range of options and possibilities of cure and care. Communities and consumers often need all the help and expertise they can get to solve their problems, but any such programmes should be clearly based on their prerogatives.

Ideas and technical innovations in self-care can, and do, flow in both directions. The appeals of self-care and self-help can be expected to grow as self-diagnostic and self-treatment technology is developed, as the demand for caring services supersedes demand for curative services, and as continuing economic pressures mount to reduce inappropriate use of professional services.

4. Prevention versus coping

An important objective of health care is to help persons with diseases or disability to cope with the situation. As much as 85% of all care is lay-provided, but neither the individual nor the family receives sufficient supportive health education to cope with chronic illness, disabilities or acute illness behaviour.

The achievement of health for all is a process leading to the goal of more equality in health, defined in terms of better health services for all and of more direct involvement of people in their own health. At the same time, many health problems have their origin in structural inequalities that cannot be solved by health education but must be taken into account in the planning and practice of learning about health. That is why in some cases health education of professionals and decision-makers can be just as urgently needed as health education of the public.

Annex 2

IDENTIFICATION OF FUNCTIONS AND TASKS IN PRIMARY HEALTH CARE
SUMMARY OF WORK OF GROUPS

Group A: Problems related to lifestyles[a]

The group first classified lifestyle problems according to their effects on health:

(1) those with direct, quantifiable, effects such as alcohol abuse, smoking, narcotics abuse, unsuitable diets;

(2) those with less direct and less measurable effects such as styles of working associated with stress, and various forms and intensities of exercise; and

(3) general lifestyles with uncertain effects but with implications for health care such as non-conformity (e.g. single parenthood in some societies), isolation and loneliness, migrancy, itinerancy, and some lifestyles associated with social-class distinction.

This kind of listing and classification would provide a basis for a PHC team to make a community survey and a community diagnosis of lifestyle problems; to determine priorities for health action and feasibility of action; to decide on the combinations of health care staff and others, including members of the public or of voluntary groups, to be assigned to a specific problem or to specific dimensions of problems; to look for resources; to determine which competencies have to be learned or upgraded, and which team members have to be trained.

Lifestyle problems can also be classified according to amenability to change of factors that affect lifestyles. Thus "external" factors such as laws, commercial interests, advertising, social norms, practices associated with different religions, and the form and quality of a PHC service are mostly amenable to change. "Internal" factors that influence lifestyles, mainly biological and psychological, are generally not amenable to change by PHC action.

The group took smoking as a typical problem for an exercise which a PHC team would undertake to determine the competence of the team to bring about a reduction in its prevalence and health effects. It identified target groups - the public in general, school pupils in early adolescence, smokers who want to stop smoking, smokers at special risk, e.g. diabetics or expectant mothers or certain occupational groups. The group then identified particular professional and non-professional health workers who could be assigned to specific target groups, their tasks, and the different groups of skills they would need in order to perform these tasks.

The group considered such an exercise as an instance of identifying educational needs and using education in a selective and discriminating way to achieve a specific and measurable result in respect of a lifestyle problem.

Group B: Problems related to the physical and social environment

The group pointed out a general problem in this context - the lack of health information systems that would provide the data needed to establish priorities with regard to problems and to their various dimensions in a local community; such systems are needed also to monitor and evaluate progress in dealing with these problems. PHC teams must organize and contribute systematically to local community information systems and use them for community diagnostic and evaluation purposes, and for keeping communities informed about health problems on which they can themselves take action.

The group listed the following as typical problems related to the physical and social environment:

- traffic problems (particularly in relation to youth);
- work insecurity and unemployment, occupational hazards, pollution risks, defective working environments;

[a] The group used as a working paper the abridged version of the document: Regional programme in health education and lifestyles (Annex 1(b)).

- nutritional problems;
- the health problems associated with demographic changes and with changes in family structure;
- problems of drug dependency;
- child abuse;
- problems associated with poverty (of individuals and families);
- infectious and degenerative diseases with important environmental and social associations.

This category was seen to overlap considerably with problems related to lifestyles.

As a basis for designing continuing education programmes or exercises as a support measure for dealing with the problems they had identified, the group selected traffic problems and carried out an exercise such as a PHC team would do.

First, the problem is assessed on the basis of data collected on traffic risks, e.g., accidents, noise, air pollution; on traffic movement, e.g., density of vehicles, most-used routes; on the movement of children with regard to residence, school, public park and playing spaces. Secondly, this information is analysed. Thirdly, the information is disseminated with the object of motivating people to take action to reduce the health risks associated with traffic, e.g., by small local exhibitions, the medium of parents' associations, various kinds of community meetings. Fourthly, action is taken, e.g., health education, as a basis for changing traffic movements, for stimulating community participation in dealing with the problem, and for changing the behaviour of individuals in relation to traffic.

The competence which a PHC team should have available to perform these functions are: (i) epidemiological competence (not of a highly technical order), and an epidemiological rather than a clinical way of viewing the problems of traffic accidents; (ii) ability to recognize and respond to the social dimensions of traffic problems; (iii) ability to identify and interact with important sources of health information from outside the health sector, e.g., police, traffic and transport authorities; (iv) simple biostatistical skills; (v) communicational skills; and (vi) organizational skills.

The group considered also the constitution of a PHC team concerned with the health problems associated with road traffic and decided that the nuclear primary care team, or a health manager, or the continuing education adviser, or all three, or all three in consultation with traffic authorities, could determine who the members of the health team would be for this particular problem. The health manager or the continuing education adviser, or both, would assess the competency of the team to carry out the identified functions and either introduce staff who possess the skills that are not available to the health team or to a continuing education service, or arrange training for particular members of the health team to perform the necessary tasks, with regard, e.g., to the collection and analysis of data, the dissemination of data, and the action taken to deal with the health problems. This again is an example of a selective, discriminating use of an educational service to support a primary health care team in relation to a particular kind of primary care problem.

Groups C and D: Failings of health services

A public health approach to disease control or health protection, with its elements of epidemiology, health statistics, and information sciences, is not reflected in the structure or the methods of primary care even when certain conditions or aspects of service would facilitate such an approach, e.g., salaried practice and responsibility for whole populations, or the existence, as in the United Kingdom, of an almost complete population denominator in the form of general practitioners' lists and of age-sex registers. Doctors are often not aware of, nor does the public expect, ways of providing health care, or of using time and other resources, which would be more productive and, for health care staff, more satisfying if less convenient than practice based almost solely on the conventional medical consultation in the practitioner's office. Primary care teams where they exist tend to be concerned almost exclusively with medical care, and unless their physician members are oriented towards comprehensive health care their non-medical members are likely to function as extenders of clinical care rather than in the interests of health protection or promotion.

Continuing education has reinforced the medical emphasis of primary care; it has been provided for the medical profession almost exclusively, and by medical educators and specialists. It has not been concerned with diffusing an epidemiological "way of thinking" throughout health care services or with multidisciplinary team development. It has not promoted problem-solving in respect of the medicosocial, psychosocial, and psychological problems for which many patients consult primary care practitioners: rather, especially when sponsored by pharmaceutical enterprises, it has reinforced the tendency of doctors to "medicalize" such problems.

Some countries equate continuing education in support of primary care with the processing of all general practitioners at regular fixed intervals through a system of medical education which is geared to the number of general practitioners in the health services and to a fixed length and pattern of education. One effect is that nurses, who are much more numerous than physicians, have little or no access to continuing education.

The modelling of continuing education largely on conventional undergraduate medical education, as regards its "message" and its methods, has the effect that like much of undergraduate medical education it often has little relevance to primary medical care, much less to primary health care. This contributes to the devaluation by the public of primary care and to the over-use of secondary or hospital care in many countries - a special dimension of the problem of non-availability or non-accessibility of primary care.

Primary care staff often perform below their potential, even in clinical care; both undergraduate and continuing education, especially in medicine, contribute to this state of affairs because of, for one reason, the influence of hospital specialists at both phases of medical education and, for another reason, the failure of health authorities and the health professions to devise a form of primary care practice that would supersede hospital medicine in the value systems of both the public and the health professions because of its beneficial effects on health. This does not imply a downgrading of primary medical care; on the contrary, high-quality primary medical care is an essential element of the spectrum of health care competencies comprised in primary health care. One of the aims of health professional education systems, including their continuing-education phases, must be to realize the potential of medical care in this context.

Annex 3

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